BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: JASON C. Claimant, vs. CENTRAL VALLEY REGIONAL CENTER, Service Agency.	OAH No. 2005090754

DECISION

Administrative Law Judge Robert Walker, State of California, Office of Administrative Hearings, heard this matter in Fresno, California, on March 3, 2006.

Shelley Celaya, Client Appeals Specialist, represented Central Valley Regional Center.

Antoinette Taillac, Deputy Public Defender, represented the claimant, Jason C.

SUMMARY AND ISSUES

Claimant applied to regional center for services. Regional center denied his application, and he appeals.

Is claimant eligible for regional center services? That is the ultimate issue.

Claimant contends that he comes within the, so called, fifth category of eligibility. That is, he contends that he has a disabling condition that is closely related to mental retardation or that he has a disabling condition that requires treatment similar to that required

for individuals with mental retardation.[1] The qualifying conditions are discrete. One can qualify for services if he or she has a disabling condition that is closely related to mental retardation. And one can qualify if he or she has a disabling condition that requires treatment similar to that required for individuals with mental retardation.

Intermediate issues include the following:

1. Does claimant have a disabling condition? (There is no dispute about the fact that he does.)

2. Did claimant's disability originate before he attained age 18? (Claimant is 15 years old.)

3. Can claimant's disability be expected to continue indefinitely?

4. Does claimant's disability constitute a substantial disability for him?

5. Is claimant's disabling condition one that is closely related to mental retardation?

6. Is claimant's disabling condition one that requires treatment similar to that required for individuals with mental retardation?

7. Is claimant's condition solely physical in nature?

8. Is claimant's condition solely a psychiatric disorder?

9. Is claimant's condition solely a learning disability?[2]

FACTUAL FINDINGS

BACKGROUND

1. Claimant, Jason C., was born on January 14, 1991. He is 15 years old.

2. In 2004 claimant was living at T & D Group Home, and regional center received an application to provide services to him pursuant to the Lanterman Act.[3] Carol

[1] The, so called, fifth category is found in Welfare and Institutions Code, section 4512, subdivision (a).

[2] The first seven of these issues are derived from Welfare and Institutions Code, section 4512, subdivision (a). Issues numbers eight and nine are derived from the California Code of Regulations, title 17, section 54000, subdivision (c).

Sharp, Ph.D., a staff psychologist with the regional center, evaluated school district records and concluded that claimant has attention and distractibility problems but that he has an average non-verbal IQ.

3. A regional center eligibility assessment team concluded that claimant was not developmentally disabled and, therefore, not eligible for regional center services. Regional center notified claimant that he was not eligible. Claimant appealed, and the hearing in this matter followed.

THE OPINIONS OF EXPERTS REGARDING CLAIMANT'S CONDITION

4. Regional center agreed to reconsider claimant's application and retained Stanley F. Littleworth, Ph.D., to evaluate him. On December 29, 2004, Dr. Littleworth interviewed claimant. On January 6, 2005, Dr. Littleworth administered a battery of tests and wrote a psychological evaluation.

5. Dr. Littleworth reviewed Fresno Unified School District records. He wrote that, when claimant was three years and two months old, the school district administered the Merrill Palmer, the DASI, and the Vineland Adaptive Behavior Scale. The Merrill Palmer showed a one year cognitive delay. The DASI showed an eleven month cognitive delay. And the Vineland showed a nine month adaptive behavior delay. Based on these tests, the school district evaluated claimant "as having Significantly Below Average General Intellectual Functioning with concurrent adaptive behavior delays (mental retardation)." This evaluation qualified claimant for special education.

6. Dr. Littleworth reported that, when claimant was six years, one month of age, an administration of the Kaufman Assessment Battery for Children placed his cognitive ability in the below average range. When claimant was twelve years, nine months of age, an administration of the Wechsler Individual Achievement Test placed his grade equivalent in reading and decoding at first grade and placed his grade equivalent in math reasoning at late kindergarten.

7. In 2000 the school district changed claimant's special education qualifying criterion from mental retardation to "Specific Learning Disability." At the time of Dr. Littleworth's evaluation, claimant received special education services because of an evaluation of emotional disturbance and specific learning disability.

8. Dr. Littleworth reviewed claimant's medical records. Beginning at age five, claimant received a number of diagnoses from various physicians. When claimant was ten, Dr. Fernandez at Children's Hospital raised the possibility of claimant's having a "Pervasive Developmental Disorder."

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[3] The Lanterman Developmental Disabilities Services Act begins at Welfare and Institutions Code, section 4400.

9. Dr. Littleworth administered the Wechsler Intelligence Scale for Children – Third Edition (WISC – III), the Wide Range Achievement Test – Revision 3, and the Bender Visual - Motor Gestalt Test.

10. On the WISC – III, claimant scored a verbal IQ of 59 and a performance IQ of 78, which produce a full scale IQ of 66. Claimant's verbal comprehension index was 60. His scores on the language based subtests fell at the 0.3 percentile level, which means that his performance was no better than that of the lowest one percent of the population.

11. On the visual-spatial and configuration tasks, however, claimant did much better. He scored in the low average level. Thus, there was a significant discrepancy in subtest scores.

12. In defining the term "general intellectual functioning," The American Psychiatric Association's Diagnostic and Statistical Manual, fourth edition, Text Revision, (DSM IV TR) addresses the circumstance in which there is a significant discrepancy – or scatter – in scores. The DSM IV TR says that when there is significant scatter the mathematically derived IQ may not accurately reflect the person's abilities and may be misleading. The DSM IV TR says:

> When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.[4]

13. Thus, in claimant's case, the full scale IQ of 66 may not accurately reflect his learning abilities.

14. Dr. Littleworth dealt with the discrepancy in scores by calculating a perceptual organization index. This produced a much higher score because that index does not include the score on the coding test, which was one of claimant's lowest scores. With that recalculation, claimant's performance IQ went from 78 to 87, which is low average. And Dr. Littleworth concluded that this was the most reliable estimate of claimant's intellectual potential. Dr. Littleworth wrote:

> Jason's Full Scale IQ of 66, [which is] in the deficient range, does not represent a reliable estimate of his overall level of intellectual functioning. The current assessment would rule out the presence of Mental Retardation and is consistent with prior

[4] DSM IV TR, p. 42.

> assessment suggesting that Jason's low academic skills are associated with learning disabilities.
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> …
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> *Jason's severe impairment in verbal abilities, low academic and adaptive skills may cause him to function like an individual with mental retardation. He would appear significantly handicapped in communication, learning, and self care.* (Italics added.)

15. Dr. Littleworth made a few recommendations. One was that claimant be in a structured, supportive, and supervised residential facility. Another was that the regional center should determine whether claimant was eligible for regional center services.

16. On February 3, 2005, after receiving Dr. Littleworth's evaluation, regional center affirmed Dr. Sharp's original decision that claimant is not developmentally disabled and, therefore, not eligible for regional center services.

17. By June of 2005, claimant was no longer living at T & D Group Home. He was incarcerated in the Juvenile Hall Detention Center with charges pending against him for assault with intent to rape, false imprisonment by violence, and second-degree robbery.

18. The Fresno County Superior Court appointed Harold Seymour, Ph.D., to do a competency assessment to determine whether claimant was competent to stand trial. Dr. Seymour interviewed claimant, attempted to administer the Revised Competency Assessment Instrument, and did administer other tests. Dr. Seymour wrote a report dated June 30, 2005. He wrote that he was unable to administer the Revised Competency Assessment Instrument in large part because of claimant's very limited vocabulary. Dr. Seymour did administer the reading scale of the Wide Range Achievement Test – Revised, which indicated that claimant, at 14 years old, was reading at a first grade level. Dr. Seymour also administered portions of the Wechsler Intelligence Scales and determined that claimant "appears to be functioning in the Mildly Mentally Retarded range of intelligence." Dr. Seymour wrote:

> Overall, he is clearly well below the threshold for what would be considered minimally competent to stand trial. Additionally, his serious cognitive limitations suggest he would be unlikely to attain competence. He most likely would require the appointment of a legal guardian.

19. Dr. Seymour wrote that he was "offering" diagnoses of "Impulse Control Disorder, Not Otherwise Specified, and Mild Mental Retardation." He wrote that claimant "will likely always require supportive services and supervision." Dr. Seymour recommended a referral to the regional center for evaluation and treatment planning. He wrote that claimant

"would most likely require a setting specializing in individuals with developmental disabilities."

20. Laura Geiger, Ph.D., is a clinical psychologist and is the clinical director of Collegium Scientifica in Fresno. Dr. Geiger testified in the present proceeding. In 2005, the superior court appointed Dr. Geiger to do a competency assessment. In Dr. Geiger's present position, she does not have occasion to diagnose mental retardation. She, however, does have specialized training in diagnosis and for two years worked in a program in which she did diagnose mental retardation.

21. Dr. Geiger conducted a clinical interview of claimant, administered a competency examination, and did an assessment. She did not do any testing. Dr. Geiger did the interview and assessment on August 9, 2005, and wrote a psychological evaluation dated that same date. She concluded that claimant was not competent to stand trial.

22. As a result of the assessment, Dr. Geiger suspected that claimant's cognitive level was impaired, that is, that claimant lacks the intellectual skills necessary to function as people commonly do. Dr. Geiger did not have records of IQ scores, but she suspected cognitive impairment because claimant seemed to have an extremely limited vocabulary and extremely limited verbal skills.

23. Dr. Geiger's diagnoses were tentative. In her August 9, 2005, psychological evaluation she wrote that "Jason *appears* to have a dual diagnosis of both a mental disorder and a developmental disability." (Italics added.) She wrote that claimant has a "*probable* developmental disability marked by deficits in his cognition, social skills, and other activity of daily living." (Italics added.)

24. Dr. Geiger did not do a formal assessment of claimant's adaptive functioning. She, nevertheless, concluded that claimant has "problems with activities of daily living." Dr. Geiger testified that she concluded that claimant's adaptive functioning is impaired. She arrived at that conclusion, in part, based on information the detention center staff provided to her regarding claimant's day-to-day behavior at the detention center. When other boys teased claimant, he became upset. Claimant's behavior resulted in the staff placing him in lockdown status in a single cell. Also, in Dr. Geiger's evaluation, she wrote that, when she interviewed claimant, he was poorly groomed.

25. Dr. Geiger diagnosed borderline intellectual functioning. She also wrote that there was a need to explore the possibility of "mild mental retardation and attention deficit disorder with aggressive outbursts."

26. Dr. Geiger recommended a referral to the regional center.

27. On August 25, 2005, the Fresno County Office of the Public Defender asked regional center, again, to reconsider its decision. The public defender submitted Dr.

Seymour's June 30, 2005, competency assessment and Dr. Geiger's August 9, 2005, psychological evaluation and asked regional center to review those.

28. Thomas Keenen, MA, is the program manager of the regional center eligibility unit. The regional center concluded that Dr. Seymour's assessment and Dr. Geiger's evaluation did not contain any information that should cause regional center to change its decision that claimant is not eligible for regional center services. In response to the public defender's request for reconsideration, Mr. Keenen wrote a letter dated August 26, 2005, to The Honorable Dale Ikeda, Judge of the Superior Court. Mr. Keenen pointed out that Dr. Littleworth's testing showed that claimant is not mentally retarded. He pointed out, also, that neither Dr. Seymour not Dr. Geiger had the sort of data one needs in order to diagnose mental retardation. Mr. Keenen wrote that claimant has failed to demonstrate that he has a developmental disability.

29. In September of 2005, the office of the public defender asked Dr. Geiger to review Dr. Littleworth's report and Mr. Keenen's August 26, 2005, letter. Dr. Geiger reviewed those and wrote a report dated September 18, 2005. Dr. Geiger was critical of Dr. Littleworth's having recalculated claimant's IQ score by factoring out the low subtest score – the score on the coding test. On cross examination, however, she said that she did not know whether leaving out that score is an acceptable practice.

30. On October 4, 2005, the superior court ordered an additional evaluation. This one was by Errol F. Leifer, Ph.D., a Diplomat of the American Board of Professional Psychology, a Diplomat of the American Board of Professional Neuropsychology, and a Diplomat of the American Board of Forensic Examiners. Dr. Leifer is in private practice in Fresno and is a Senior Neuropsychologist at Children's Hospital.

31. Dr. Leifer interviewed claimant on October 22, 2005, and reviewed a number of records, including the reports by Dr. Littleworth, Dr. Seymour, and Dr. Geiger.

32. Certain tests that other evaluators had administered tend to test expressive language. Dr. Leifer chose to administer the Peabody Picture Vocabulary Test III because it involves pointing to pictures and does not require verbal responses. It is considered to be more reflective of receptive language skills. Claimant scored a standard score of 68, which is on the high side of the mild mental retardation range. That score represented an age equivalence of between seven years ten months to eight years eight months, which was six to seven years below complainant's age.

33. Dr. Leifer wrote a psychological evaluation dated October 22, 2005.

34. In resolving the conundrum presented by claimant's very low scores on language based tests but higher performance on visual-spatial and configuration tests, Dr. Leifer disagreed with Dr. Littleworth. Dr. Leifer wrote:

> Many individuals with a level of functioning that appropriately and accurately fits within the category of mild mental retardation have some cognitive skills that can be near or at average in functional integrity. [Claimant's] . . . verbal functioning is much more indicative of his actual functional ability than the non-verbal, visual spatial and configural abilities demonstrated on the intellectual assessment tasks. It is not simply that Jason has a limited vocabulary, but that the thought and cognitive level capacities of comprehension, understanding and thinking that are integral to adaptive daily life functional status are grossly impaired and defective. Daily life adaptive skill and competencies does not depend upon such non-verbal skills, but upon cognitive processes highly dependent upon and integrated with language process skills.
>
> The central issue is the actual practical and daily functional status of the individual in the day-to-day world of what is generally expected of someone that age. From the information reviewed and tests administered, Jason functions at a level of understanding, conception, reasoning, problem solving, and comprehension that is decidedly below average and operational within the mildly mentally retarded level of ability.
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> . . .
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> Jason's grossly impaired learning and functional history, along with his impulsivity, aspects of ADHD, and aggressive reactivity strongly implicate a mal-development of his brain. There certainly are historical circumstances regarding his birth and early development that are consistent with such an implication of brain impartment in the deficiency of developmentally appropriate and adaptive competencies historically demonstrated by Jason.

35. Dr. Leifer also testified in this proceeding. He testified that Dr. Littleworth's conclusion that claimant's cognitive abilities are of a borderline intellectual level is not correct.

36. Dr. Leifer testified that, from an adaptive and functional perspective, claimant is mildly mentally retarded. He testified that claimant is not capable of improving his verbal functioning skills and that he needs to be in a highly supervised environment with a heavy emphasis on teaching daily skills.

37. Dr. Leifer said that the fact that claimant has mental health problems does not mean that he cannot be mentally retarded. Some mentally retarded people have mental health problems in addition to low cognitive ability. Claimant does have mental health problems and needs psychotropic drugs to help control his aggressive behavior.

38. Dr. Sharp, the regional center's staff psychologist, testified. Dr. Sharp is a former teacher. She is a clinical psychologist with a specialty in child psychology. She has been with the regional center for over two years and spends a substantial amount of time assessing applicants and determining whether they are developmentally disabled.

39. Dr. Sharp noted that, in diagnosing mental retardation, one should use a standardized IQ test and a standard measure of adaptive functioning.

40. Dr. Sharp testified that IQ subtest scores with significant discrepancy or scatter tend to indicate a learning disability rather than mental retardation.

41. Dr. Sharp referred to the subtest scores Dr. Littleworth obtained in his testing and noted the substantial discrepancy. Dr. Sharp then referred to the statement in the DSM IV TR that "When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading."[5] She testified that Dr. Littleworth dealt with the scatter by calculating a perceptual organization index. This produced a much higher score because that index does not include the score on the coding test, which was one of claimant's lowest scores. Dr. Sharp testified that Dr. Littleworth's approach was particularly appropriate in this case because the coding test involves time constraints and may not be a good indication of the capabilities of someone like claimant who has attention difficulties.

42. Dr. Sharp was critical of Dr. Geiger, Dr. Seymour, and Dr. Leifer for their conclusions that claimant is mentally retarded. She noted that they were not asked to determine whether claimant was developmentally disabled. They were assessing competency to stand trial. Dr. Sharp also pointed out that Dr. Geiger administered no tests and that there is no record of which subtests Dr. Seymour used. Finally, she testified that the Peabody Picture Vocabulary Test III, which Dr. Leifer administered, is not an IQ test.

43. Dr. Sharp testified that claimant's handicaps are the result of his learning disabilities and mental health problems and that he does not require treatment similar to that required for individuals with mental retardation. Dr. Sharp testified that the diagnosis of mild mental retardation at age three was not conclusive because IQ does not stabilize until a child is between seven and nine years old.

44. On cross examination, Dr. Sharp acknowledged that she has not met or tested claimant. She is relying on the records and reports she had reviewed. She testified that she

[5] *Ibid.*

was relying in part on Dr. Littleworth's report, but she disagreed with his conclusion that "Jason's severe impairment in verbal abilities, low academic and adaptive skills may cause him to function like an individual with mental retardation."

REGIONAL CENTER'S ACKNOWLEDGMENT THAT CLAIMANT REQUIRES INCREMENTAL TEACHING IN TASKS THAT ARE VERBALLY BASED

45. In a letter dated October 3, 2005, from Amy Westling, Client Appeals Specialist for Central Valley Regional Center, to Donna Miller, Deputy Public Defender, Ms. Westling explained why the regional center had concluded that claimant is not developmentally disabled and, therefore, not eligible for regional center services. Ms. Westling said, in part, "Jason's academic records indicate that he requires assistance due to significant learning disabilities. In this sense, the services he receives are not similar to someone with mental retardation *as he requires incremental teaching only in tasks that are verbally based*." (Italics added.)

WHAT IS MENTAL RETARDATION?

46. In determining whether claimant has a disabling condition that is closely related to mental retardation or that requires treatment similar to that required for individuals with mental retardation, it is helpful to know something about mental retardation.

47. The DSM IV TR identifies three criteria – one "essential" criterion and two other criteria -- used in diagnosing mental retardation. The "essential" criterion is "significantly subaverage general intellectual functioning." A second criterion is that the subaverage general intellectual functioning must be "accompanied by significant limitations in adaptive functioning . . . ." And the third and final criterion is that "the onset must occur before age 18 years."[6]

GENERAL INTELLECTUAL FUNCTIONING

48. The DSM IV TR provides that:

> General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children-Revised, Stanford-Binet, Kaufmann Assessment battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of

[6] DSM IV TR, p. 41.

> approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus it is possible to diagnose mental retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior . . . . When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.[7]

49. The DSM IV TR also provides for distinguishing among levels of intellectual impairment depending on the degree of severity of a party's mental retardation. The levels are as follows:

> Mild … IQ … 50-55 to approximately 70
> Moderate … IQ … 35-14 to 50-55
> Severe … IQ … 20-25 to 35-40
> Profound … IQ … below 20 or 25[8]

50. According to the DSM IV TR, people with mild mental retardation:

> typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth grade level.[9]

51. A person with and IQ between 71 and 84, if not mentally retarded, is considered to be of borderline intellectual functioning. The DSM IV TR provides:

> Borderline Intellectual functioning . . . describes an IQ range that is higher than that for Mental Retardation (generally 71 – 84). As discussed earlier, an IQ score may involve a measurement error of approximately 5 points, depending on the testing instrument. Thus, it is possible to diagnose Mental Retardation in individuals with IQ scores between 71 and 75 if

[7] *Id*. at p. 41 - 42.

[8] *Id*. at p. 42

[9] *Id*. at p. 43.

> they have significant deficits in adaptive behavior that meet the criteria for Mental Retardation. Differentiating Mild Mental Retardation from Borderline Intellectual Functioning requires careful consideration of all available information.[10]

CLAIMANT'S LEVEL OF COGNITIVE FUNCTIONING

52. What is the level of claimant's ability to acquire knowledge and make judgments? Does claimant's condition involve something that resembles the essential criterion for diagnosing mental retardation? That is, does it involve something that resembles significantly subaverage general intellectual functioning?

53. All of the professionally trained people who tested and assessed claimant concluded either that he is mentally retarded or that his deficits may cause him to function like an individual with mental retardation. Dr. Seymour concluded that claimant was functioning in the mildly mentally retarded range and that claimant's serious cognitive limitations suggest that it is unlikely that he will attain competence. Dr. Leifer concluded that, from an adaptive and functional perspective, claimant is mildly mentally retarded and is not capable of improving his verbal functioning skills. And Dr. Littleworth concluded that claimant's "severe impairment in verbal abilities, low academic and adaptive skills may cause him to function like an individual with mental retardation."

54. Dr. Geiger, who did no testing, but who interviewed claimant and administered a competency examination, suspected that claimant's cognitive level was impaired.

55. Dr. Sharp, based on her review of the records and reports, disagrees. Her conclusion, in large part, is based on the testing that Dr. Littleworth did. Dr. Sharp testified that Dr. Littleworth's approach to dealing with the marked discrepancy in claimant's scores was appropriate, and her testimony in that regard was very credible. The perceptual organization index that resulted from Dr. Littleworth's recalculation supports a finding that claimant is not mentally retarded. Moreover, Dr. Leifer qualified his conclusion that claimant is mentally retarded. Dr. Leifer testified that claimant is mildly mentally retarded *from an adaptive and functional perspective*. (Italics added.)

56. But even Dr. Littleworth, on who's testing Dr. Sharp relies, concluded that claimant's "severe impairment in verbal abilities, low academic and adaptive skills may cause him to function like an individual with mental retardation."

57. On balance, it is found that claimant has a disabling condition that is closely related to mental retardation.

ADAPTIVE FUNCTIONING

[10] *Id.* at p. 48.

58. The DSM IV TR criterion regarding limitations in adaptive functioning concerns limitations "in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, work, leisure, health, and safety."[11]

> Impairments in adaptive functioning rather than low IQ are usually the presenting symptoms in individuals with Mental Retardation. Adaptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. *Adaptive functioning may be influenced by* various factors, including education, motivation, personality characteristics, social and vocational opportunities, and *the mental disorders and general medical conditions that may coexist with Mental Retardation.* Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.[12] (Italics added.)

EXPERT OPINION REGARDING CLAIMANT'S ADAPTIVE FUNCTIONING

59. As noted above, Dr. Littleworth wrote:

> Jason's severe impairment in verbal abilities, low academic and adaptive skills may cause him to function like an individual with mental retardation. He would appear significantly handicapped in communication, learning, and self care.

60. Dr. Littleworth's conclusions concerning claimants adaptive functioning appear to be based on his observations and on a Vineland assessment that was done in 1994, when claimant was three years old.

61. In Dr. Geiger's September 18, 2005, report, she reviewed the information that is available concerning claimant's adaptive functioning. Dr. Geiger wrote that her own observations and Dr. Littleworth's evaluation indicate that claimant is significantly disabled in his communication skills, learning ability, self-care skills, and social skills. Dr. Geiger testified that her conversations with the staff at the detention center also caused her to conclude that claimant has deficits in adaptive functioning.

62. Dr. Leifer does not discuss adaptive functioning as a separate matter as is contemplated by the DSM IV TR. Rather, he wrote about claimant's adaptive functioning as

[11] *Id.* at p. 41.

[12] *Id*. at p. 42.

though – because of claimant's extremely poor language processing skills – it must follow that he has deficits in adaptive functioning. As noted above, he wrote:

> Daily life adaptive skill and competencies does not depend upon such non-verbal skills, but upon cognitive processes highly dependent upon and integrated with language process skills.

63. Because Dr. Leifer writes about adaptive functioning as though it were simply determined by claimant's poor cognitive skills, his report does not shed any light on adaptive functioning as a discrete element of the diagnosis.

64. Dr. Sharp had little to say about adaptive functioning. Her opinion that claimant is not mentally retarded and does not have a condition similar to mental retardation is based primarily on Dr. Littleworth's testing of claimant's cognitive abilities.

65. The DSM IV TR recommends that one gather evidence regarding deficits in adaptive functioning from one or more reliable independent sources e.g. teacher evaluation and educational, developmental, and medical history.

> Several scales have also been designed to measure adaptive functioning or behavior (e.g. the Vineland Adaptive Behavior Scales and the American Association on Mental Retardation Adaptive Behavior Scale). These scales generally provide a clinical cutoff score that is a composite of performance in a number of adaptive skill domains.[13]

66. The record in this proceeding, unfortunately, is rather unsatisfactory regarding claimant's adaptive functioning. The Vineland Adaptive Behavior Scale that was administered was done when claimant was three years old – twelve years ago. It would have been useful if someone had done a current assessment with one of the scales designed to measure adaptive functioning and with evidence from an independent source who was familiar with claimant.

67. Nevertheless, on balance, it is determined that the evidence supports a finding that claimant has significant limitations in adaptive functioning in at least the areas of communication and self-care.

[13] *Ibid.*

DOES CLAIMANT HAVE A SUBSTANTIAL DISABILITY AND, IF SO, CAN IT BE EXPECTED TO CONTINUE?

68. The California Code of Regulations defines substantial handicap as follows:

> "Substantial handicap" means a condition which results in major impairment of cognitive and/or social functioning. Moreover, a substantial handicap represents a condition of sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential.[14]
>
> Since an individual's cognitive and/or social functioning are many-faceted, the existence of a major impairment shall be determined through an assessment which shall address aspects of functioning including, but not limited to: (1) Communication skills; (2) Learning; (3) Self-care; (4) Mobility; (5) Self-direction; (6) Capacity for independent living; [and] (7) Economic self-sufficiency.[15]

69. As noted above, Dr. Seymour concluded that claimant was functioning in the mildly mentally retarded range and that claimant's serious cognitive limitations suggest that it is unlikely that he will attain competence. Dr. Leifer concluded that, from an adaptive and functional perspective, claimant is mildly mentally retarded and is not capable of improving his verbal functioning skills. And Dr. Littleworth concluded that claimant's "severe impairment in verbal abilities, low academic and adaptive skills may cause him to function like an individual with mental retardation."

70. In Dr. Geiger's report, she wrote that claimant's history strongly indicates his "need for combined interdisciplinary services or other forms of assistance, which most likely will be chronic or of extended duration."

71. It is found that claimant has a substantial disability that can be expected to continue indefinitely.

WHAT TREATMENT IS REQUIRED FOR INDIVIDUALS WITH MENTAL RETARDATION?

72. The parties offered little evidence on this point. The DSM IV TR, however, contains a modest amount of information concerning treatment. In discussing people with mild mental retardation, the DSM IV TR says:

[14] Cal. Code Regs., tit. 17, § 54001, subd. (a).

[15] *Id*. at subd. (b).

> During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.[16]

73. In discussing people with moderate mental retardation, the DSM IV TR says:

> They profit from vocational training and, with moderate supervision, can attend to their personal care. They can also benefit from training in social and occupational skills . . . . They may learn to travel independently in familiar places . . . . In their adult years, the majority are able to perform unskilled or semiskilled work under supervision . . . .[17]

WHAT TREATMENT DOES CLAIMANT'S DISABLING CONDITION REQUIRE?

74. Certainly claimant needs mental health services.

75. As noted above, Dr. Littleworth recommended that claimant be in a structured, supportive, and supervised residential facility.

76. Dr. Seymour recommended that claimant be placed in a residential setting that provides for structured supervision along with the administration of medication. He wrote that claimant most likely will require a setting specializing in individuals with developmental disabilities.

77. Dr. Geiger concluded that claimant needs comprehensive, long term services to alleviate the consequences of his low intelligence and defects in adaptive functioning. Dr. Geiger wrote that claimant's history strongly indicates his "need for combined interdisciplinary services or other forms of assistance, which most likely will be chronic or of extended duration." And Dr. Geiger testified that claimant's vocabulary score on the WISC – III that Dr. Littleworth administered was the lowest possible score one could have. She said that claimant will require extensive assistance with communication, social functioning, daily living, and job training. Dr. Geiger testified that claimant will need a structured, supportive environment. She said that these treatments are similar to the treatments that people who are mentally retarded require.

[16] DSM IV TR, p. 43.

[17] *Ibid.*

78. As noted above, Dr. Leifer testified that claimant is not capable of improving his verbal functioning skills and that he needs to be in a highly supervised environment with a heavy emphasis on teaching daily skills.

79. Dr. Sharp testified regarding her conclusion that claimant does not need treatment similar to that required for individuals with mental retardation.

80. It is found that claimant needs to be in a structured, supportive, and supervised residential facility. He needs extensive assistance with communication, social functioning, daily living, and job training. He needs to be in a facility that emphasizes teaching daily skills.

81. Ms. Westling, in her October 3, 2005 letter, while not intending to make any concessions, wrote that claimant "requires incremental teaching only in tasks that are verbally based." And that was an acknowledgment that, regarding tasks that are verbally based, claimant does require incremental teaching.

82. It is found that claimant requires treatment similar to that required for individuals with mental retardation.

LEGAL CONCLUSIONS

1. The Lanterman Act is an entitlement act. People who are eligible under it are entitled to services and supports.[18]

> The purpose of the statutory scheme is twofold: to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community (citations) and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community (citations). [19]

2. The act is a remedial statute and, as such, must be interpreted broadly.[20]

3. A developmental disability is a "disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual." The term includes mental retardation,

[18] *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.

[19] *Id.* at p. 388.

[20] California State Restaurant Association v. Whitlow (1976) 58 Cal.App.3d 340, 347.

cerebral palsy, epilepsy, autism, and what is commonly referred to as the "fifth category."[21] The fifth category includes "disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation."[22]

4. Thus, individuals whose IQ scores do not fall squarely within the range of mental retardation can be eligible under the fifth category.

5. The regulations implementing the act provide that conditions that are solely psychiatric in nature, solely learning disabilities, or solely physical disabilities are not considered to be developmental disabilities.[23]

6. A substantial handicap is a "condition which results in a major impairment of cognitive and/or social functioning" which requires "interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential."[24] Whether an individual suffers from a substantial disability in cognitive or social functioning depends on his or her functioning in a number of areas, including: communication skills, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency.[25] Cognitive functioning has to do with "the ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience."[26]

7. By reason of the matters set forth in Findings 4 through 44, 52 through 57, and 59 through 67, it is determined that claimant has a disabling condition that is closely related to mental retardation.

8. By reason of the matters set forth in Findings 4 through 45, 52 through 57, 59 through 67, and 74 through 82, it is determined that claimant's disabling condition requires treatment similar to that required for individuals with mental retardation.

9. By reason of the matters set forth in Findings 4 through 44, 52 through 57, and 59 through 71, it is determined that claimant's disability constitutes a substantial disability for him and can be expected to continue indefinitely.

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[21] Welf. & Inst. Code, § 4512, subd. (a).

[22] *Ibid.*

[23] Cal. Code Regs., tit. 17, § 54000, subd. (c) (1), (2), & (3).

[24] *Id.* at § 54001, subd. (a).

[25] *Id.* at § 54001, subd. (b).

[26] *Id.* at § 54002.

10. The evidence does not support a finding that claimant's condition is solely physical in nature, solely a psychiatric disorder, or solely a learning disability.

11. It is determined that claimant is eligible for regional center services.

ORDER

The appeal of claimant, Jason C., from the service agency's denial of his application is granted.

DATED: March 28, 2006

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ROBERT WALKER
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.